TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dennis E Karasek MD

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-4048-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We perform UDS on our patients as part of their on-going treatment and based on ODG guidelines for UDT drug monitoring."

Amount in Dispute: $644.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No evidence the requestor, a non-network provider, received out of network approval to provide the service or treatment. Nor has the requestor provided any such evidence in its DWC-60 packet."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2014	Urinary Drug Screens	$644.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the requirements for filing a medical fee dispute.
2. Texas Insurance Code 1305.103 sets out the requirements for treating doctor referrals.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - A02 – Provider not approved to treat Texas Star network Claimant
   - A05 – Services exceeds recommendations of treatment guidelines
   - B5 – Coverage/program guidelines were not met or were exceeded
   - 16 – Claim/service lacks information or has submission/billing error (s)

- 243 – Services not authorized by network provider
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 724 – No additional payment after a reconsideration

Issues

1. Was the provider approved to provide out-of-network treatment?

Findings

1. The respondent states in their position statement, "No evidence the requestor, a non-network provider, received out of network approval to provide the service or treatment. Nor has the requestor provided any such evidence in its DWC-60 packet."

   Review of the submitted documentations finds the following;

   "Claim Administration System DM – Maintain History 09/05/12, Non Network Referral, Date Non Network referral approved: 09/04/12. Name of Provider, Karasek, Dennis MD… Rationale: Approved Dr. Dennis Karasek due to no pain management in the area/network. Signed: Tonja Hamilton."

   Review of the submitted medical claim finds the NPI listed as the rendering provider in box 24J of the submitted medical claim is 1154495430 which are linked to Dale J Weaver PA. This is also the name found in box 31 of the submitted medical claim. Insufficient evidence was found to support that an out of network referral was given for the rendering provider.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 31, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.